



# TEXAS

## Health and Human Services

Open Enrollment  
For  
***Health and Human Services Commission  
Medicaid/CHIP Division  
Health Information Exchange (HIE) Connectivity Project  
Strategy 1: Medicaid Provider HIE Connectivity (Strategy 1)  
Enrollment Number: HHS0000396***

Enrollment Period Opens: May 21, 2019

Enrollment Period Closes: July 19, 2019

NIGP Class/Item Code: 920-27

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## 1. GENERAL INFORMATION

The State of Texas, by and through the Health and Human Services Commission (HHSC), seeks applications for an open enrollment to identify Local Health Information Exchange Organizations (Local HIEs) with which to contract. Local HIEs receiving Contracts will participate in the implementation of Strategy 1: Medicaid Provider HIE Connectivity (Strategy 1). This project should increase the amount of Clinical Data available for exchange between Medicaid providers and provide HHSC with Clinical Data.

To be considered for award, Applicants must execute **Exhibit A: Affirmations and Solicitation Acceptance**, of this Solicitation and provide all other required information and documentation as set forth in this Solicitation.

### 1.1 Scope

Strategy 1 will use this open enrollment to accept multiple Local HIEs which meet the criteria in [Subsection 1.5](#) into the project. The accepted Local HIEs will receive a Contract, adhere to the requirements of Strategy 1, Onboard Medicaid providers who use Certified Electronic Health Record Technology (CEHRT) to a Local HIE, and acquire infrastructure to Connect to HHSC through connectivity with the State-Level Shared Services Organization.

### 1.2 Point of Contact

The HHSC Point of Contact for inquiries concerning this open enrollment until the completion of the initial application screening is:

Nicole Acclis, CTCM, HHSC Contract Manager,  
Phone: 512-438-3507  
Email: [Nicole.Acclis@hhsc.state.tx.us](mailto:Nicole.Acclis@hhsc.state.tx.us)

Applicants shall direct all procurement communications relating to this open enrollment to the HHSC Point of Contact named above.

### 1.3 Procurement Schedule

At HHSC's discretion, all dates may change. The HHSC Point of Contact identified in [Subsection 1.2](#) must receive applications by the enrollment closing period provided in the Procurement Schedule below.

Procurement Schedule	
Open Enrollment Period Opens	5/21/2019
Questions Due from Potential Applicants	6/28/2019, 5:00 PM CDT
Answers to Questions to be Posted	7/10/2019, 5:00 PM CDT
Open Enrollment Period Closes	7/19/2019, 2:00 PM CDT
Post Awards to <a href="#">HHSC Opportunities Page</a>	As Contracts Reach Execution
Anticipated Initial Contract Start Date	8/1/2019

## **1.4 Background**

### **1.4.1 Overview of the HHSC**

Since 1991, HHSC has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC is established in accordance with Texas Government Code Chapter 531 and is responsible for the oversight of all Texas Health and Human Services System.

For more information regarding HHSC and its programs visit: <https://hhs.texas.gov/>.

### **1.4.2 Overview of Strategy 1**

Since 2010, public and private resources significantly invested in Texas to migrate healthcare providers to Electronic Health Records (EHRs), establish a statewide HIE infrastructure, and establish Local HIEs to help providers exchange Clinical Data and coordinate care. Strategy 1 capitalizes on the investments made to promote HIE adoption by providers in Texas and ensures HHSC recognizes value from the investment in HIE infrastructure. Further development of the statewide HIE infrastructure will expand the ability for Clinical Data to exchange securely between health care entities within Texas, while aiding in the movement toward a more efficient healthcare system.

Strategy 1 serves as one of three current strategies developed by HHSC to leverage the federal Health Information Technology for Economic and Clinical Health (HITECH) Act matching funds designated for development of health information technology systems. While Strategy 1 seeks to Connect Medicaid providers to Local HIEs, Strategy 2: HIE Infrastructure (Strategy 2) will aid in connecting those organizations to the State-Level Shared Services. This also creates the linkages necessary to move Clinical Data from Local HIEs to HHSC. Strategy 3: Emergency Department Encounter Notification (EDEN) system (Strategy 3) applies the connectivity enabled by the first two strategies. Strategy 3 will utilize hospital data to quickly notify a patient's care team members when the patient enters an emergency department (ED).

HHSC recognizes the potential benefits of its Medicaid providers, as well as other HHSC stakeholders, exchanging Clinical Data. The significance for HHSC to receive Clinical Data from Medicaid providers has increased. HHSC has created Strategy 1 to increase the number of Medicaid providers exchanging Clinical Data amongst themselves and sending Clinical Data to HHSC.

These strategies will execute in a manner which utilizes infrastructure for the benefit of all Texans independent of Medicaid status.

## **1.5 Eligible Applicants Criteria**

For eligibility to receive a Contract resulting from this open enrollment, Applicants must meet the following criteria:

- 1.5.1 Submit the completed **Exhibit B: Application for Enrollment** and supporting documentation.
- 1.5.2 Free to participate in state contracts and not be debarred by the Texas Comptroller of Public Accounts:  
[http://comptroller.texas.gov/procurement/prog/vendor\\_performance/debarred/](http://comptroller.texas.gov/procurement/prog/vendor_performance/debarred/).
- 1.5.3 Free to participate in federal contracts with the System of Award Management (SAM). Determination of the Applicant's ineligibility to apply for funds under this open enrollment include the following: currently debarred, suspended, or otherwise excluded or ineligible for participation in Federal or State assistance programs. Search the federal excluded list at the following website:  
<http://www.sam.gov/portal/public/sam>.
- 1.5.4 Authorized as a public or private entity to do business in Texas with the Secretary of State: <https://direct.sos.state.tx.us/acct/acct-login.asp>.
- 1.5.5 Free of exclusions with the US Department of Health and Human Services, Office of Inspector General. <https://exclusions.oig.hhs.gov/default.aspx>.
- 1.5.6 Free from negative reports in the Vendor Performance Tracking System on the Centralized Master Bidders List (CMBL):  
<https://mycpa.cpa.state.tx.us/tpasscmbsearch/index.jsp>.
- 1.5.7 Identify as a Local or Regional HIE (see [Definitions](#) for additional information) in Texas.
- 1.5.8 Demonstrate the Applicant's active engagement in the business of HIE in Texas during the past 12 consecutive months preceding the date of application. Examples of active Local HIE engagement include:
- Connecting providers (Onboarding hospital or ambulatory providers) to the Applicant's Local HIE;
  - Securely exchanging Clinical Data electronically;
  - Have a current Local HIE Sustainability Plan; or
  - Held a Board of Directors meeting within the past 12 months.

## 1.6 Strategic Contract Elements

### 1.6.1 Contract Type and Term

HHSC intends to award multiple Contracts resulting from this open enrollment. The initial Contract term will begin on the effective date stated in the Contract and will end on September 30, 2020, **(subject to CMS approved funding and legislative appropriations)** unless renewed, extended, or terminated pursuant to the terms and conditions of the Contract. HHSC reserves the option to renew the term of the Contracts for an additional one-year term, or as necessary to complete the mission of this open enrollment. Contracts awarded as a result of this open enrollment will include the signature

document and all attachments thereto, **Exhibit C:** HHSC Uniform Terms and Conditions, and **Exhibit D:** HHSC Special Conditions. HHSC reserves the right to negotiate additional Contract terms and conditions.

### **1.6.2 Data Use Agreement (DUA) and Security and Privacy Initial Inquiry (SPI)**

If a Contract with HHSC is executed as a result of this Solicitation, Applicant agrees to be bound by the terms of the HHSC Data Use Agreement (**Exhibit E: HHSC Data Use Agreement**) and Applicant must complete a Security and Privacy Initial Inquiry (**Exhibit F: Security and Privacy Initial Inquiry**).

## **1.7 Amendments and Announcements Regarding Open Enrollment**

HHSC will post all official communication regarding this open enrollment on the [HHSC Opportunities Page](#). HHSC reserves the right to revise the open enrollment at any time and to make unilateral amendments to correct grammar, organization, and clerical errors. Each Applicant holds the responsibility to comply with any changes, amendments, or clarifications posted to the [HHSC Opportunities Page](#). Applicant must check the [HHSC Opportunities Page](#) frequently for changes and notices of matters affecting this open enrollment.

Applicant's failure to periodically check the [HHSC Opportunities Page](#) will in no way release the Applicant from "addenda or additional information" resulting in additional costs to meet the requirements of the open enrollment.

The HHSC Point of Contact identified in [Subsection 1.2](#) must receive all questions and comments regarding this open enrollment. Questions must reference the appropriate page and subsection number. HHSC will post subsequent answers to questions to the [HHSC Opportunities Page](#). HHSC reserves the right to amend answers prior to the open enrollment closing date.

Applicants should notify the HHSC Point of Contact identified in [Subsection 1.2](#) of any ambiguity, conflict, discrepancy, omission, or other error in the open enrollment information.

## **1.8 Interpretive Conventions**

Use of the terms "shall," "must," or "is required" in conjunction with a specification or performance requirement in this open enrollment indicates the specification or requirement is mandatory.

Use of the terms "can," "may," or "should" in conjunction with a specification or performance requirement means the specification or performance requirement in this open enrollment indicates a desirable, but not mandatory, requirement.

## **1.9 Delivery of Notices**

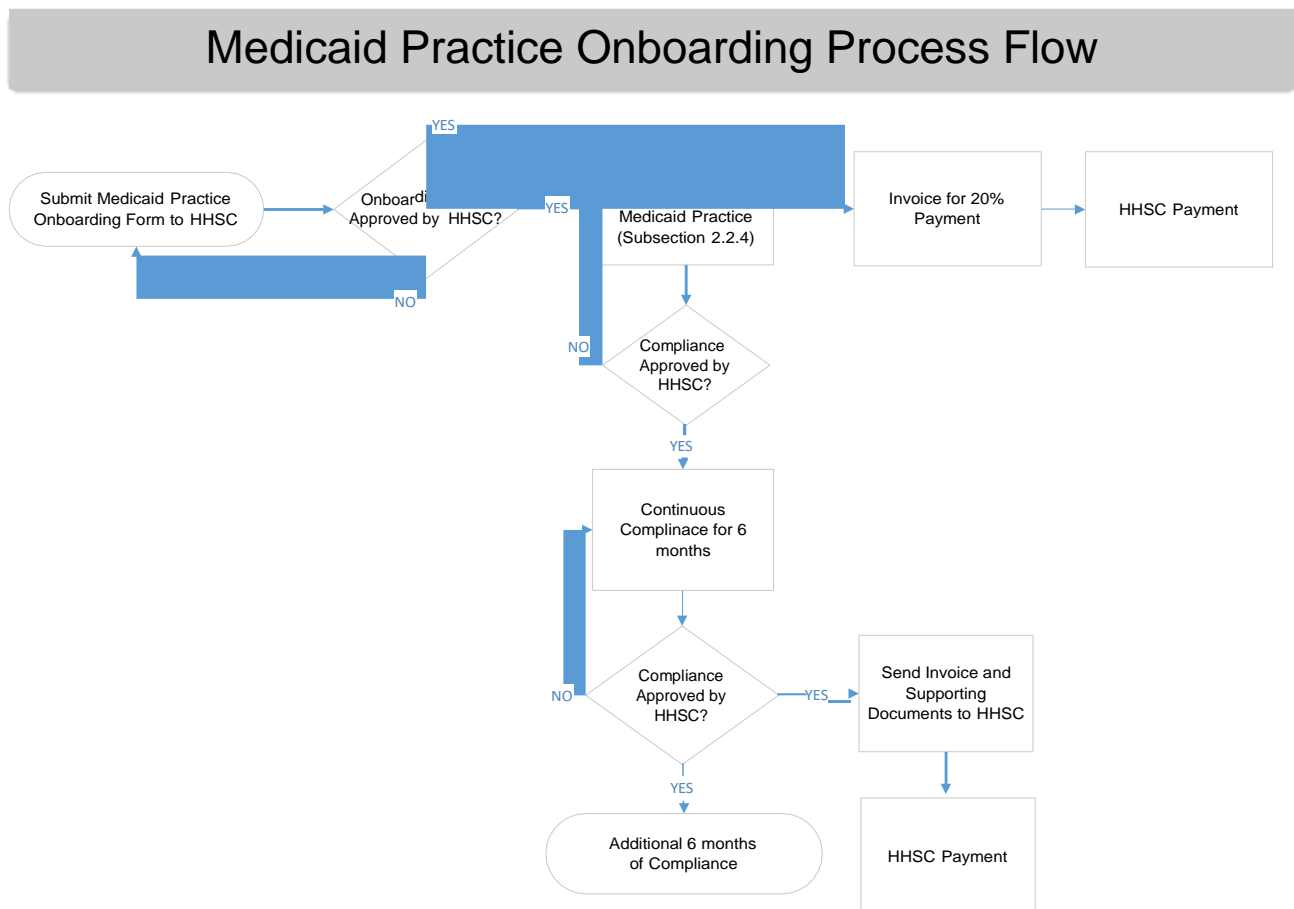
The HHSC Point of Contact noted in [Subsection 1.2](#) of this open enrollment must receive any notice required or permitted under this announcement in writing. At all times, the Applicant will maintain and monitor at least one active email address for the receipt of Application-related communications from HHSC. The Applicant holds responsibility to monitor this email address for Application-related information.

## 2. STATEMENT OF WORK

### 2.1 Strategy 1 Summary

Strategy 1 connects Medicaid providers to the Local HIEs according to the requirements in [Subsection 2.2.4](#). These requirements fulfill the Strategy 1 goals of enabling Medicaid providers to exchange Clinical Data amongst themselves and delivering Clinical Data to HHSC via the State-Level Shared Services.

A high-level review of the Medicaid Practice Onboarding Process Flow proceeds as follows:



### 2.2 Contractor Requirements

#### 2.2.1 The Contractor must:

CR.01	Submit <b>Exhibit G: Medicaid Practice Onboarding Form</b> for HHSC's approval for each Medicaid practice to Onboard (for additional information see <a href="#">Subsection 2.2.4</a> ) prior to commencing with each connection.  After obtaining HHSC's approval on the <b>Exhibit G: Medicaid Practice Onboarding Form</b> , the Contractor has six months to connect to the
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	Medicaid provider and obtain approval from HHSC or the form must be resubmitted for approval. Extensions can be granted at HHSC's sole discretion.
CR.02	Maintain an updated Organizational Chart reflecting any changes in key staff.
CR.03	Maintain an updated Sustainability Plan.
CR.04	Maintain a connection to the State-Level Shared Services.
CR.05	Notify HHSC of any changes to Medicaid providers (additions or deletions within a practice) within 30 days of the change in a format and media determined by HHSC.

### 2.2.2 Contractor Meeting and Reporting Requirements

CMR.01	The Contractor must provide monthly status reports on each Medicaid provider the Contractor connects to their Local HIE. The HHSC Contract Manager or agency designee must receive the status reports by the close of business on the fifth business day of the next month throughout the life of the Contract.
CMR.02	The monthly status report provided by the Contractor must include all work performed and completed during the month as well as the work planned to be performed during the subsequent month including all <b><u>Exhibit G: Medicaid Practice Onboarding Form</u></b> submitted to HHSC.
CMR.03	The Contractor must include in the monthly status report: details on the progress made towards Onboarding Medicaid providers to the Local HIE, details on any barriers encountered during the month, or issues in completing the Onboarding with any needed explanations.
CMR.04	The Contractor must participate in monthly status calls to review Strategy 1 progress, address issues and concerns, and document recommendations.
CMR.05	The Contractor must provide a comprehensive status report at the end of the Contract.
CMR.06	<p>All reports and supporting documentation containing Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA) must utilize encryption to meet applicable HIPAA privacy and security standards.</p> <p>Acceptable formats for all communications and reports include Microsoft Word, Excel, or in searchable portable document format (.pdf) files, unless otherwise specified.</p>



### 2.2.3 Providers Eligible for Onboarding

Contractors will submit an **Exhibit G: Medicaid Practice Onboarding Form** to begin the process of Onboarding Medicaid providers meeting at least one of the following criteria:

- Participating in the Texas Medicaid EHR Incentive Program and providing services to Medicaid patients within the six months prior to the Local HIE's submission of a Medicaid Practice Onboarding Form (**Exhibit G: Medicaid Practice Onboarding Form**);
- Participating in Medicare programs focused on Meaningful Use of EHRs and providing services to Medicaid patients within the six months prior to the submission of the Medicaid Practice Onboarding Form, whose Medicaid patient volume exceeds 10 percent and have patients under the care of Eligible Providers in the Medicaid EHR Incentive Program; or
- Necessary Clinical Data exchange partners (e.g., providers participating in referral networks) for those providers participating in the Texas Medicaid EHR Incentive Program, as determined by HHSC. For additional information see [State Medicaid Director \(SMD\) Letter #16-003](#).

Contractors must ensure all providers they Onboard are not connected to any other Local HIE Contractor.

### 2.2.4 Provider Connectivity Methods

Contractors will Connect individual providers with EHR implementations by any one of the three connectivity methods listed below (dependent on type of Medicaid provider).

#### 2.2.4.1 Ambulatory EHR Onboarding for Exchange of C-CDA ToC Summaries

The Contractor will enroll the Medicaid provider as a member of the Local HIE and deliver all standard Local HIE Services normally available through a membership. After notification from the Local HIE of completion of setup, HHSC will review the provider's connectivity. The duration of the Local HIE Services must continue for a minimum of 12 months. Local HIE Services must include the ability of the Medicaid provider to query and access the Clinical Data shared by members of the Local HIE. Local HIE Services must make Clinical Data at the provider's practice available for sharing with other providers connected to the Local HIE.

The Contractor will deliver to HHSC, via the State-Level Shared Services, Consolidated Clinical Document Architecture Transition of Care (C-CDA ToC) Summaries for at least 95 percent of the Medicaid clients seen by a provider's primary practice location. A Contractor's connections with providers are subject to the payment limitation described in [Subsection 3](#). The payment limitations in [Subsection 3](#) do not negate a Contractor's responsibilities to ensure all Medicaid patient encounters within the practice have accountability via C-CDA ToC Summaries transmitted to HHSC.

C-CDA ToC Summaries must arrive at the Local HIE and transmit to HHSC, via the State-Level Shared Services, within 35 days of a patient's visit and must reflect updated data resulting from the visit. Subject to the availability of funds, the Contractor must ensure the transmission of Clinical Data continues for at least 12 months. In the case of providers practicing between separate organizations with distinct EHR implementations, this requirement applies only to the specific EHR implementation for which the Local HIE proposed implementing connectivity.

HHSC must receive original, unmodified C-CDA ToC Summary documents produced by the Medicaid provider's EHR system and the C-CDA ToC Summary documents must conform to the highest version level of C-CDA ToC Summary documents available in the version of EHR in use by the Medicaid provider. Any future versions of the C-CDA ToC Summary, or Centers for Medicare and Medicaid Services (CMS)-designated replacement, will fulfill the requirements of this section.

#### **2.2.4.2 Hospital Onboarding for Exchange of C-CDA ToC Summaries**

Contractor will deliver to HHSC, via the State-Level Shared Services, C-CDA ToC Summaries for at least 95 percent of the Medicaid clients having ED encounters and inpatient admissions. C-CDA ToC Summaries must arrive at the Local HIE and transmit to HHSC within 35 days of an inpatient discharge or ED visit. Subject to the availability of funds, the Contractor will ensure the provision of these summaries for at least 12 months. In the case of providers practicing between separate organizations with distinct EHR implementations, this requirement applies only to the specific EHR implementation for which the Local HIE proposed implementing connectivity.

HHSC must receive original, unmodified C-CDA ToC Summary documents produced by the Medicaid provider's EHR system and the summary documents must conform to the highest version level of ToC Summaries available in the version of EHR in use by the Medicaid provider. In the event CMS revises or develops a replacement for the C-CDA ToC Summary those revisions will fulfill the requirements of this section. In no event will Contractors be required to utilize these replacements.

#### **2.2.4.3 Hospital ED Onboarding for Health Level Seven (HL7) ADT-based Clinical Data**

Contractor must transmit the EDEN Minimum Data Set, and any additional data volunteered by the hospital, to the State-Level Shared Services for use by the EDEN system. ED admissions data must transmit within one hour upon registration within the ED's information system and its availability for export. Subject to the availability of funds, the Contractor must ensure the provision of the EDEN Minimum Data Set for at least 12 months.

### **3. PAYMENT and INVOICING**

#### **3.1 Availability of Funds**

- 3.1.1** Appropriations and the continuing availability of federal funds and state general revenue funds will govern any awarded open enrollment Contract.
- 3.1.2** If funds for these Contracts become unavailable, HHSC may immediately terminate or reduce the amount of the resulting Contract(s) at the sole discretion of HHSC. Contractors will have no right of action against HHSC if HHSC cannot perform its obligations under this Contract due to a lack of funding for any activities or functions outlined within the Scope and Statement of Work Sections of this open enrollment.
- 3.1.3** HHSC does not guarantee funding at any level and may increase or decrease funds at any time during the term of any Contract resulting from this open enrollment.
- 3.1.4** Contractors may not use funds received from HHSC to replace any other federal, state, or local source of funds awarded under any other contract.
- 3.1.5** Payments will ensue per provider connected and proven to transfer C-CDA-based or ADT-based records on a regular, ongoing and timely basis.
- 3.1.6** Contractors may request payment for up to three ambulatory providers in a practice over the course of Strategy 1.
- 3.1.7** Contractor must provide a copy of the agreement(s) between the Medicaid provider and the Local HIE and request a review of the Medicaid provider's connection by HHSC when the connection to the State-Level Shared Services is complete and data flow is established. HHSC will provide approval of the connection.
- 3.1.8** Contractor must request HHSC's review of the Medicaid provider's data flow once it has been continuous for six months. HHSC will provide an approval of the continuous data flow.
- 3.1.9** The HHSC Contract Manager must receive all invoicing according to [Subsection 3.3](#).

#### **3.2 Method of Payment**

- 3.2.1** The Contract resulting from this open enrollment will provide for an individual payment to the Contractor each time HHSC has approved that the Contractor has satisfied the requirements of [Subsection 2.2](#). The Cost Per Provider refers to the amount of payment, stated in the Contract, associated with the method of connectivity implemented for the specified provider. The requirements in [Subsection 2.2.4](#) list three distinct methods of connectivity for which HHSC will make payment.
- 3.2.2** The Contractor may only request payment for up to three ambulatory providers in a practice over the course of Strategy 1.

- 3.2.3** Contractor may request an Optional Milestone Payment of 20 percent of the total Cost Per Provider for each **Exhibit G: Medicaid Practice Onboarding Form** approved by HHSC.
- 3.2.4** HHSC reserves the right at any time to stop accepting and approving **Exhibit G: Medicaid Practice Onboarding Forms** at its sole discretion.
- 3.2.5** Any Optional Milestone Payments will be deducted from the total Cost Per Provider amount when invoicing for final payment.
- 3.2.6** Payment will be paid after compliance with the requirements in [Subsection 3.3.1](#).
- 3.2.7** Contractors must have submitted monthly status reports to HHSC to receive payment for services provided.
- 3.2.8** Funding will be allocated equally among Local HIEs receiving a Contract. HHSC may, in its sole discretion, reallocate Contract funds from Contracts resulting in this Open Enrollment based on Contractors' performance during the term of the Contract.

### **3.3. Invoicing Process**

The Contractor must submit completed invoices for each connection after six months of continuous data flow. Project documentation must accompany invoices (for additional information see [Subsection 3.3.1](#)). Payment for completed connectivity, as described in [Subsection 2.2.4](#), will depend upon a review of transmitted C-CDA ToC Summaries or ADT feed to ensure compliance with published documentation standards.

If the Contractor elects to receive an Optional Milestone Payment per provider, as described in [Subsection 3.2](#), the Contractor must invoice HHSC within 30 days upon receipt of HHSC's approval of the Local HIE's Medicaid Practice Onboarding Form (**Exhibit G: Medicaid Practice Onboarding Form**).

Email all invoices to:

Nicole Acclis, CTCM, HHSC Contract Manager,  
Phone: 512-424-6508, Email: [Nicole.Acclis@hhsc.state.tx.us](mailto:Nicole.Acclis@hhsc.state.tx.us)

- 3.3.1** Invoice Billing Statements to HHSC must include:
- The Contractor's name, address, telephone number and email address, Contract and invoice number, description of services and the amount billed.
  - A completed and signed Purchase Voucher and a Purchase Order in which HHSC will provide upon execution of a written Contract.
  - For the Optional Milestone Payment, include a copy of the HHSC approval of the Medicaid Practice Onboarding Form.
  - When the Contractor meets the requirements in [Subsection 2.2.4](#), the final payment can be invoiced. Include in the invoice:
    - Copy of the HHSC's approval of connection.
    - Copy of the HHSC's approval of six months of continuous data flow.

- Signed affirmation stating the connection meets the requirements in [Subsection 2.2.4](#).

### **3.4. Recoupment of Funds**

- 3.4.1 In the event the Contractor receives an Optional Milestone Payment but fails to Onboard a Medicaid Practice within the time frame allowed by HHSC, Contractor will be required to repay all of the Optional Milestone Payment to HHSC within 90 business days from the date of HHSC's request for payment.
- 3.4.2 In the event the Contractor does not fulfill its requirement to ensure connectivity for 12 months for each Medicaid Practice Onboarded, as required in [Subsection 2.2.3](#) and [Subsection 2.2.4](#), Contractor may be required to repay all, or a pro rata portion, of the total payments made to Contractor by HHSC under the Contract resulting from this procurement. The amount to be repaid by the Contractor will be determined by HHSC, in its sole discretion, on a case-by-case basis.

## **4. INFORMATION AND SUBMISSION INSTRUCTIONS**

### **4.1 Open Enrollment Cancellation/Partial Award/Non-Award**

At its sole discretion, HHSC may cancel this open enrollment, make a partial award, or make no awards.

### **4.2 Right to Reject Applications or Portions of Applications**

At its sole discretion, HHSC may reject any and all applications or portions thereof.

### **4.3 Joint Applications**

HHSC will not consider joint or collaborative applications requiring it to Contract with more than one Applicant in a single Contract.

### **4.4 Withdrawal of Applications**

Applicants have the right to withdraw their Application from consideration at any time prior to Contract award by submitting a written request for withdrawal to the HHSC Point of Contact as designated in [Subsection 1.2](#).

### **4.5 Costs Incurred**

Applicants understand that issuance of this open enrollment in no way constitutes a commitment by HHSC to award a Contract or to pay any costs incurred by an Applicant in the preparation of a response to this open enrollment. HHSC is not liable for any costs incurred by an Applicant prior to issuance of or entering into a formal agreement, Contract, or purchase order. Costs of developing responses, preparing for or participating in oral presentations and site visits, or any other similar expenses incurred by an Applicant are

entirely the responsibility of the Applicant and will not be reimbursed in any manner by the State of Texas.

#### **4.6 Exhibit B: Application for Enrollment Submission Instructions**

**4.6.1** Applicant must submit an electronic copy of all required documents as searchable versions (.pdfs) according to the dates in [Subsection 1.3](#). To permit HHSC to open the documents, Applicants must ensure no encryptions would prevent HHSC from opening the documents. The electronic Application submission must be organized as directed in [Subsection 4.7](#) of this open enrollment. If the Applicant has difficulty providing an electronic Application submission, contact the HHSC Point of Contact identified in [Subsection 1.2](#) of this open enrollment.

**4.6.2.** Submission of an Application does not execute a Contract.

#### **4.7 Organization of Electronic Submission of Application**

Applicant must organize its scanned and signed **Exhibit B: Application for Enrollment** and application supporting documentation in the following order and format. The **Exhibit B: Application for Enrollment** and supporting documentation listed in the application must be included in the electronic copy and labeled accordingly.

#### **4.8 Electronic Copy**

**4.8.1** Label the body of the email and each supporting document with:

- Name of the Organization
- Organization's Point of Contact
- Organization's Point of Contact's job title
- Organization's Point of Contact's telephone number and email address
- HHSC Procurement Number of this open enrollment
- Date of submission

#### **4.9 Delivery of Applications**

**4.9.1** Submit all applications and supporting documents to HHSC via email.

Delivery Option
<p>Health and Human Services Commission  Nicole Acclis, CTCM, HHSC Contract Manager,  Phone: 512-424-6508, Email: <a href="mailto:Nicole.Acclis@hhsc.state.tx.us">Nicole.Acclis@hhsc.state.tx.us</a></p> <p><b>HHSC will not accept Applications by any other method of delivery (e.g., telephone or facsimile).</b></p>

**4.9.2** All Applications become the property of HHSC after submission.

## **5. ELIGIBILITY DETERMINATION**

### **5.1 Initial Compliance Screening**

HHSC will perform an initial screening of all Applications received.

If the Application passes the initial screening, the Applicant will be contacted for further instructions or actions.

### **5.2 Unresponsive Applications**

Unless Applicant has taken action to withdraw **Exhibit B: Application for Enrollment**, HHSC will consider Applications unresponsive and will not advance for further consideration when any of the following conditions occurs:

**5.2.1** The Applicant fails to meet major open enrollment specifications, including:

**5.2.1.1** The Applicant fails to submit the required **Exhibit B: Application for Enrollment** and supporting documentation by the closing of the Open Enrollment period provided in [Subsection 1.3](#).

**5.2.1.2** The Applicant fails to meet the eligibility requirements under [Subsection 1.5](#) of this open enrollment.

**5.2.2** The Application does not include a signature.

### **5.3 Corrections to Application**

Applicants have the right to amend their Application at any time prior to an unresponsive decision or Contract award decision by submitting a written amendment to the HHSC Point of Contact, as designated in [Subsection 1.2](#). HHSC may request modifications to the Application at any time.

## **5.4 Review and Validation of Applications**

The Applicant must provide full, accurate, and complete information as required by this open enrollment.

As part of the application review process, HHSC staff may validate any aspect of the application. Validation may consist of an on-site visit, review of records, and any other source of information available to the public.

## **5.5 Additional Information**

By submitting an Application, the Applicant grants HHSC the right to obtain information from any lawful source regarding the Applicant, its directors, officers, and employees including, but not limited to:

- Past business history, practices, and conduct.
- Ability to supply the goods and services.
- Ability to comply with Contract requirements.

By submitting an Application, an Applicant generally releases from liability and waives all claims against any person or entity providing HHSC information about the Applicant. HHSC may take such information into consideration in screening or the validation of information on an Application or supporting documentation.



## 6. ACRONYMS AND DEFINITIONS

### 6.1 Acronyms

ADT	Admission, Discharge, and Transfer
C-CDA	Consolidated Clinical Document Architecture
C-CDA ToC	Consolidated Clinical Document Architecture Transition of Care
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Plan
CMBL	Centralized Master Bidders List
CMS	Centers for Medicare & Medicaid Services
DUA	Data Use Agreement
ED	Emergency Department
EDEN	Emergency Department Encounter Notification
EHR	Electronic Health Record system
FFY	Federal Fiscal Year
HHSC	Texas Health and Human Services Commission
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
HL7	Health Level Seven
IAPD-U	Implementation Advanced Planning Document-Update
ONC	Office of the National Coordinator for Health IT
PCS	Procurement and Contracting Services
PHI	Protected Health Information
.pdf	Portable Document Format
SAM	System of Award Management
SMD	State Medicaid Director
SPI	Security and Privacy Initial Inquiry

Strategy 1	Strategy 1: Medicaid Provider HIE Connectivity
Strategy 2	Strategy 2: HIE Infrastructure
Strategy 3	Strategy 3: Emergency Department Encounter Notification system
ToC	Transition of Care

## 6.2 Definitions

As used in this open enrollment, unless the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

“Admission, Discharge, and Transfer” or “ADT” an HL7 messaging type that provides for transmitting new or updated demographic and visit information about patients.

“Ambulatory EHR” an EHR classification used by the Office of the National Coordinator for Health IT (ONC) and CMS to denote EHR systems utilized in a non-hospital setting. For more information visit: <https://www.healthit.gov/>.

“Clinical Data” the consolidated C-CDA ToC Summaries referenced in Meaningful Use and EHR certification rules published by CMS.

“Clinical Document Architecture” or “CDA” a flexible markup standard developed by HL7 defining the structure of certain medical records, such as discharge summaries and progress notes, as a way to better exchange this information between Medicaid providers and patients. These documents can include text, images and other types of multimedia -- all integral parts of EHRs.

“Connect” or “Onboard” the action of connecting a Medicaid provider to a HHSC-approved Local HIE in a manner fulfilling the requirements of the connectivity options in [Subsection 2.2.4](#).

“Consolidated Clinical Document Architecture” or “C-CDA” an implementation guide specifying a library of templates and prescribing their use for a set of specific document types.

“Consolidated Clinical Document Architecture Transition of Care Summary” or “C-CDA ToC Summary” a standard referenced in Meaningful Use and EHR certification rules published by CMS. C-CDA ToC Summaries transmitted for the purpose of filling these requirements must conform to one of the standards referenced at 45 Code of Federal Regulations (CFR)

§170.205(a), excluding the standard at §170.205(a) (2). Certification rules guarantee the capability to generate these documents from EHR versions certified in recent years.

“Contract” awarded to the selected Applicants as a result of this open enrollment.

“Contractor” the party selected to provide the goods or services under a Contract resulting from this open enrollment.

“Cost Per Provider” the reimbursement amount a Local HIE will receive from HHSC for Onboarding a Medicaid provider according to the requirements in [Subsection 1.5](#).

“EDEN Minimum Data Set” a collection of HL7 version 2 data elements, mostly derived from the patient identification segments, which provide the EDEN system with the ability to match patients between hospital HL7 admissions data and Medicaid eligibility data.

“Eligible Applicant” applicants meeting all of the criteria listed in [Subsection 1.5](#) of this open enrollment.

“Eligible Professional” or “EP” a Medicaid provider which includes: physicians, certified nurse midwives, nurse practitioners, dentists, certain physician assistants who practice in a Federally Qualified Health Center or a Rural Health Center, and doctors of optometry. These providers must have a minimum of 30 percent Medicaid patient volume (20 percent minimum for pediatricians) or practice predominantly in a Federally Qualified or Rural Health Center and have at least a 30 percent patient volume to needy individuals. For more information visit <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/MedicaidStateInfo.html>.

“Health and Human Services Commission” or “HHSC” the administrative agency established under Chapter 531, Texas Government Code or its designee.

“Health Level Seven” or “HL7” an application protocol for electronic exchange of Clinical Data in health care environments. The HL7 protocol is a collection of standard formats specifying the implementation of interfaces between computer applications from different vendors.

“Local Health Information Exchange Organization” or “Local HIE” pursuant to Section 531.901(4) of the Texas Government Code, and for purposes of this Project, a "Local or regional health information exchange" refers to a Clinical Data exchange operating in this state which securely exchanges electronic Clinical Data, including information for patients receiving services under the child health plan program or Medicaid, among hospitals, clinics, physicians' offices, and other health care Medicaid providers not owned by a single entity or included in a single operational unit or network.

“Local HIE Services” the set of standard services provided by a Local HIEs to all its registered providers. The exact services differ among Local HIEs; but, HHSC has the

expectation that applicable services will be available for all providers for the duration of the connectivity.

“Meaningful Use” the incentive program by which providers use CEHRT to: improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination, population, and public health; and maintain privacy and security of patient health information. For more information visit: <https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>.

“Medicaid Practice” the scope of an individual EHR implementation which may span multiple locations.

“Medicaid Practice Onboarding Form” (**Exhibit G: Medicaid Practice Onboarding Form**) a collection of documents and information submitted to HHSC by a Local HIE which enables HHSC to determine whether a certain, individual Medicaid provider must Onboard to the Local HIE under the terms of the Contract awarded as a result of this open enrollment. After approval the Contractor has six months to obtain approval from HHSC for the connection or the Medicaid Practice Onboarding Form must be resubmitted for approval. Extensions can be granted at HHSC’s sole discretion.

“Medicaid Providers” healthcare providers who have treatment relationships with Medicaid clients.

“Onboard” or “Connect” the action of connecting a Medicaid provider to a HHSC-approved Local HIE in a manner which fulfills the requirements of the connectivity options in [Subsection 2.2.4](#).

“Optional Milestone Payment” an optional payment available to the Contractor, at the sole discretion of HHSC, equal to 20 percent of the total Cost Per Provider for each **Exhibit G: Medicaid Practice Onboarding Form** approval by HHSC.

“State-Level Shared Services” the private and secure network which spans the entire state and supports the exchange of information between Texas HIEs and other data sources within the state, and between Texas and other authorized HIEs and federal agencies outside of Texas, as referenced in Section 7.5.1 in the [State Medicaid Health Information Technology Plan](#).

“Strategy 1: Medicaid Provider HIE Connectivity” a project with a goal to increase the amount of Clinical Data available for exchange between Medicaid providers and between providers and HHSC. The Onboarding of Medicaid providers, to Local HIEs, will facilitate electronic reporting and exchange of Clinical Data between providers and with HHSC. This open enrollment will result in Contracts with Local HIEs which further the goals of Strategy 1.

“Strategy 2: HIE Infrastructure” a project which includes enhancing the state’s HIE infrastructure to support connectivity with the state’s Medicaid system and assisting Local

HIEs in implementing connections to the State-Level Shared Services. This strategy will also include the implementation of connectivity to support these exchanges with HHSC. This strategy is not part of this open enrollment.

“Strategy 3: Emergency Department Encounter Notification (EDEN)” system is a project with a goal to produce data which can lead to the reduction of ED utilization and hospital readmissions by enabling better follow-up care and care coordination. Simplified alert messages, based upon timely Clinical Data received from hospital EDs, will be published to Medicaid partners when clients having a relationship with a partner are seen entering an ED. Notification of these Medicaid partners will facilitate timely care coordination. This strategy is not part of this open enrollment.

“Sustainability Plan” a roadmap to achieve goals which foster environmental, community, and financial sustainability.

“Transition of Care” or “ToC” the movement of a patient from one setting of care to another. When a Medicaid provider transitions their patient to another setting of care or refers their patient to another Medicaid provider of care should provide a documented summary care record to the new healthcare setting or provider.

“Transition of Care Summary” or “ToC Summary” a CDA-based document, built from C-CDA templates, required by Meaningful Use, transferring between Medicaid providers when a patient transitions or gets referred to a different care setting. CEHRT certified for Stage 2 or Stage 3 is required for capability of creating and transmitting these documents.

## **7. EXHIBITS**

- **Exhibit A: Affirmations and Solicitation Acceptance**
- **Exhibit B: Application for Enrollment**
- **Exhibit C: HHSC Uniform Terms and Conditions**
- **Exhibit D: HHSC Special Conditions**
- **Exhibit E: HHSC Data Use Agreement**
- **Exhibit F: Security and Privacy Initial Inquiry**
- **Exhibit G: Medicaid Practice Onboarding Form**